CANBERRA Doctor

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Health system reform needs medical leadership

BY PROF BRENDAN MURPHY*, CHIEF MEDICAL OFFICERR FOR THE AUSTRALIAN GOVERNMENT

One of the reasons I took on the job of Chief Medical Officer and, before that, a Health Service CEO role, was a view that health system reform is critically dependent on good medical leadership. The aspect of medical leadership that I want to talk about tonight is in the broad area of health system sustainability.

Sustainability is essentially the ability of the nation to afford to continue to provide accessible appropriate and high quality services.

There is no right amount of money per person, or proportion of GDP, that a 1st world nation should spend on health. One thing is clear, if the rate of growth in health costs is growing at 1- 2% more than the growth in GDP, the proportion of government revenue spent on health will continue to increase until it becomes unsustainable.

Engaging Clinicians

Clinicians are not motivated to control health costs for the aim of "budget repair". What will motivate them, however, is when future fiscal constraints could impact on their capacity to adopt new technology and pharmaceuticals and to maintain access to good quality 1st world patient care.

It is worth reflecting on the last few years, in which very significant savings in health care costs have been able to be achieved without materially impacting on patient care. At the Commonwealth level, the most important of these has been substantial savings in the PBS, from a range of reforms.

These savings have provided the capacity for new investments, which might otherwise have not been possible. Because of the material savings in the PBS, not only has the Commonwealth taken on hugely expensive new drugs such as the Hep C drugs, but has adopted a policy of implementing recommendations coming from the PBAC. It was not always thus and may not always be possible, if the hugely expensive pipeline of new drugs is not able to offset by further savings.

Prof Murphy addresses the AMA (ACT) AGM.

But the driver of these additional savings for *clinicians* has to be the maintenance of new investment in health and good quality care. This key change in narrative will engage clinicians in a way that 'budget repair" will never do.

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Health system reform...*continued*

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A more robust approach needed

An OECD major health summit in Jan this year concluded that about 20% of the health dollar is wasted. It also concluded that a much more robust approach to technology evaluation was the only way the explosion of new technology could be affordably implemented.

It is abundantly clear that both the management of waste and technology evaluation are only achievable with clinician leadership and that, by having the right narrative, we can broadly engage clinicians in this journey

The need to manage waste and for technology evaluation have been talked about for many years, without much tangible action. One of the exciting things I have seen in my first 9 months in the Department of Health is how we are finally starting to make some substantial inroads in both of these areas, under programs that are critically dependant on clinical leadership.

Clinician leadership

Let me give some examples where clinically led reforms can realise substantial savings with no detriment to patient care.

In the pharmaceutical area, the potential savings on biosimilars is huge. Biological agents have had a huge impact on many diseases and the companies that pioneered them have enjoyed a good return on their substantial initial investment. We are now spending nearly $3 billion a year on biologicals – close to 30% of the current PBS spend with a very high unit cost. But many patents are coming to an end and competitors are appearing. In some European countries the savings from biosimilar introduction have been huge and they have allowed the market entry of new biologicals and other new agents as well as bottom line savings. It is early days in Australia and there is significant resistance from some clinicians who are reluctant to change to these cheaper drugs.

In discussions with 'resistant clinicians' they are all universally responsive to the following counter arguments:

- Unless the suppliers of biosimilars get a fair share of the tiny Australian market, they will simply not bother bringing in future biosimilars.
- The current government policy of accepting PBAC recommendations for new drugs can only be sustained if further savings in the PBS make room for them. Given the huge future pipeline (particularly in oncology), headroom must be made.

Prof Brendan Murphy (left) with Prof Steve Robson at the AMA (ACT) AGM.

Clinicians are intensely motivated to do things to improve access, for their patients, to best quality care, including the latest drugs.

Technology assessment

What about technology assessment? This is much broader than the assessment of new technology. It also involves the methodological reassessment of existing technology and clinical practice that is being undertaken by the Medical Benefits Review.

Let me give a personal example of waste. I have OA in one knee and, prior to a partial knee replacement, I had two arthroscopies and 3 MRIs – none of which changed management. There's significant MBS and Private health fund money spent on me for no clinical benefit.

The MBS review is rightly looking at all these areas. Limitations on arthroscopy and MRI for simple OA will happen, if the right clinician leadership can be found.

Savings in the MBS will (like the PBS) create room for the MSAC approval for new items, such as trans-catheter aortic valve replacement –which recently received positive MSAC endorsement. There is a whole raft of potential genetic testing items that will be presented for MSAC evaluation. We have to make room for them.

So, in summary, I think there is huge scope for more cost effective use of the health dollar, if we meaningfully engage clinicians in the debate and leading the change. Clinical leadership, to my mind, is the cornerstone of system reform.

* This is an edited version of an address Prof Murphy gave to the AMA (ACT) Annual General Meeting on 31 May 2017.

Medical **Musings**

WITH PRESIDENT, PROFESSOR STEVE ROBSON

Mental health is everything

All of us who provide health care for Canberrans understand the fundamental importance of mental health to our community. In many ways, it underpins the wellbeing of society irrespective of all other issues. Illnesses and injuries – acute and chronic – take their course against the background of our mental health and wellbeing. For this reason, it is vital that any health system place a high priority on good mental health, and on services to work towards the best possible mental health of the community.

From the perspective of my own specialty – obstetrics and gynaecology – perinatal mental health issues have become one of the foremost causes of death and debility for pregnant women in Australia. A similar dynamic is at play in most other specialties. Parents of children and adolescents with mental health issues, and the doctors caring for them, will understand the tremendous strain and burden a family can be under. They will also understand how difficult it can be to find specialist long-term care. For these reasons, it is easy to understand the sense of frustration and dismay in the Canberra community about the availability of some mental health services.

Minister Shane Rattenbury, Minister for Mental Health in the ACT Legislative Assembly, has a big job on his hands. Along with Professor Jeff Looi – AMA Board Member, Consultant Psychiatrist, and representative for the College of Psychiatrists – I am meeting with the Minister in the next couple of weeks. High on the agenda is the urgent need to recruit specialist psychiatrists for the ACT, and the critical shortage of mental health services in Child and Adolescent Psychiatry. Minister Rattenbury failed to appoint either a GP or Psychiatrist to the ACT Mental Health Advisory Council. It is a bad start and devalues the critical role doctors play in this space. I assure you this will be on the list of topics that we discuss in person.

Legislating love

The Federal AMA launched a very public campaign in support of same-sex marriage. The campaign was not based on emotion, but on medical science. There is good evidence that couples in stable loving relationships have better health outcomes. People who are subject to discrimination – not being allowed to marry a loved one, for example – are more likely to have poorer health. The Federal AMA stance drew some criticism, but this was from a relatively small proportion of members. Open discussion and difference of opinion are the lifeblood of a civilised community, so all points of view are welcome. However, if you look at it from a health perspective, it's difficult to make a case for legislating against love.

Medical reporting

Many of you will have media reports over the last month that were, to say the least, overblown. My favourite was the breathless reporting over mouse DNA studies of mutations around NAD metabolism, leading to 'the greatest medical breakthrough in Australia's history' – a call for vitamin B3 (niacin) supplementation to end miscarriage. You may also have read reporting about 'Paleo Pete' and his idiosyncratic 'medical' opinions and advice. And don't get me started on the reporting of transvaginal mesh surgery.

All of our practices are based on sound medical science, and we value responsible and accurate reporting of medical matters. Similarly, all of us will have had worried patients contact us in a panic, responding to some media beat-up or other. The saga of the Women's Health Initiative study reporting in the early 2000s – sensationalised media reporting that saw one third of women cease HRT overnight for fear of cancer or heart attacks – should have taught some lessons. Sadly not, and the advent of social media and blogs has made the interpretation of medical science stories all the more difficult. The AMA is doing its best to respond the medical media stories and try to bring perspective. Wish us luck.

Cladding

I read with horror that the Centenary Hospital at Woden was clad in flammable materials. It is a place I know well, having worked there for fifteen years now. The ACT Government drew fire in the media for this (pun intended), but it is difficult to blame them for the fiasco. Fortunately an audit was highlighted the issue and the Government needs to move at speed to correct the problem. Delaying action puts lives at risk – the fire in the main switchboard at Canberra Hospital was dangerous, disruptive, and illustrates that point. The risk of fire had apparently been identified some time before the fire occurred – earlier action would have prevented what could have been a catastrophic outcome. Let's all hope the ACT Government learns the lessons of the recent past.

Doctor wellbeing

All of use hold concerns for the health and wellbeing of our colleagues. The number of doctors who take their own lives highlights for us the stress and pressures of a life in medicine. Unfortunately, one of the impediments to doctors seeking care for themselves is the issue of mandatory reporting. I have discussed this terrible situation in previous editions of this column, and I have brought it up directly with senior officials from ACT Health. I am not sure whether the message has sunk in, but mandatory reporting is a disincentive for doctors to seek help from their colleagues. Signs are that State and Territory Health Ministers are starting to take notice, but let us all continue to press this point – in the interests of all of our health.

COAG moves closer to a National Approach on Mandatory Reporting

The AMA has welcomed the COAG Health Council decision to develop a nationally consistent approach to mandatory reporting provisions for health practitioners.

Dr Michael Gannon, AMA President.

Following the COAG meeting on 3 August, Federal and State and Territory Health Ministers agreed to consult with practitioner and consumer groups, and develop a nationally consistent proposal for consideration at the next Health Council meeting in November 2017.

The agreement follows months of lobbying and advocacy from the Federal, State and Territory AMAs, highlighted by discussions in recent weeks between Health Minister Greg Hunt and AMA President Dr Michael Gannon.

Treating Practitioners Exemption

Dr Gannon said that the AMA has always advocated for treating practitioners to be exempted from mandatory reporting requirements.

"Mandatory reporting laws deter health practitioners from seeking early treatment for health conditions that could impair their performance," Dr Gannon said.

"We have advocated long and hard at both the federal and State level for changes the mandatory reporting provisions.

"It is an issue that the AMA and the whole medical profession feel passionately about. It affects every doctor, their families, their loved ones, and their colleagues."

Remove barriers to treatment

Delegates to the AMA National Conference in May were unanimous in seeking amendments to the mandatory reporting requirements under the National Law, so as to not dissuade medical practitioners from seeking necessary medical treatment or assistance.

The intention of the legislation was to ensure the protection of the public by requiring doctors and other health practitioners to report colleagues whose health was impaired.

But this created a barrier to access health care for health professionals, particularly in relation to mental illness. The lived experience of doctors' health advisory services across the country confirms these fears.

"Mandatory reporting undermines the health and wellbeing of doctors," Dr Gannon said.

"It is a tragic reality that doctors are at greater risk of suicidal ideation and death by suicide. This year we have lost several colleagues to suicide.

"While there are many factors involved in suicide, we know that early intervention is critical to avoiding these tragic losses.

"The AMA has identified that mandatory reporting is a major barrier to doctors accessing the care they need.

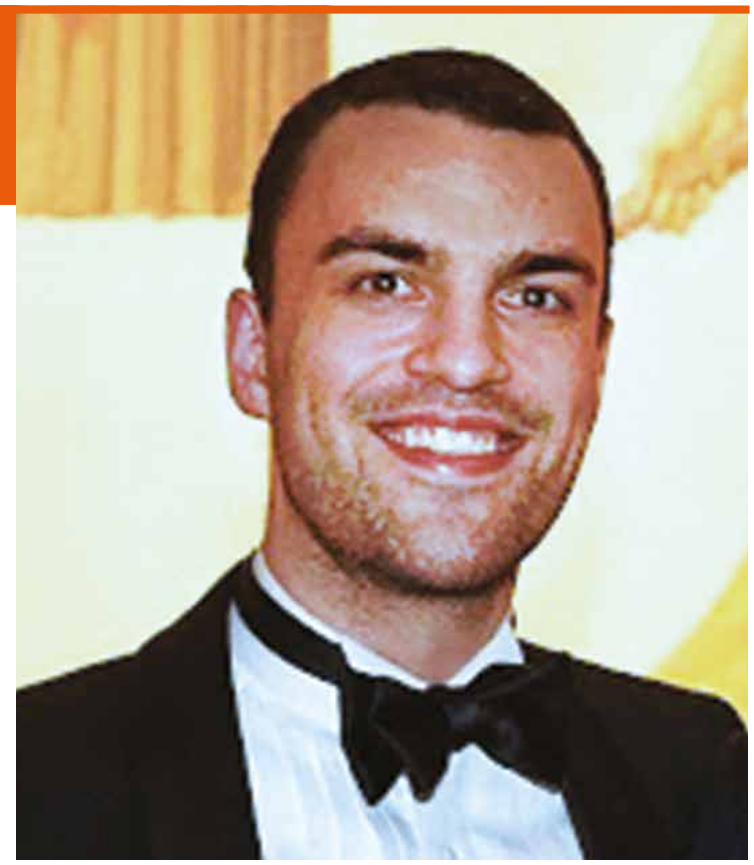
"The real work begins now. We need action from all our governments.

"The medical profession and the public need a sensible system that supports health practitioners who seek treatment for health conditions, while at the same time protecting patients.

"We urge all Health Ministers to work cooperatively to come up with an achievable agreed proposal at their next meeting."

Q&A with Dr Kieran Barr

Dr Kieran Barr is a RMO currently working in MAPU at Calvary Hospital. He is a graduate of ANU (Medicine & Surgery – 2015) and University of Melbourne (Biomedicine – 2010). Dr Barr once had the privilege of holding Roger Federer's sweaty towel when he worked as a ballkid at the Australian Open. He is also a former tractor driver, telemarketer, waiter and wardsman.



Why did you pursue a career in medicine? Is there a speciality you are interested in doing?

Medicine was always a goal because it was something difficult to get into. My parents were really supportive to challenge me to do well academically, as only ~10-15% of students in my year at high school went to university. I think I really only decided on medicine when I visited the Royal Flying Doctors' Service museum in Alice Springs in Year 11 Camp. Something about it made me think 'I'm going to do that someday'.

I haven't really found a specialty of medicine I don't like. I'm wanting to explore Emergency Medicine at this stage, as the acute generalist concept is most appealing.

If you weren't a Doctor, what would you be?

I thought I was on my way to being a 'professional' drummer in a progressive rock/nu-metal band. The evidence can be found at the 'myspace' website (does it even still exist?) by searching for a band called 'Achromic'. Failing that, I wanted to be a sound engineer. I even had a 'business' called 'Shed O Sweat' with my cousin – recording music in a tin shed in the summer holidays! Failing that, I would have liked to be a mechanical engineer working for a car manufacturer.

In your opinion, what is the most pressing issue facing Junior Doctors?

The training 'bottleneck' is our biggest issue, in my opinion. We have a discrepancy between training positions and the increase in medical school student places. This isn't helped by the announcement of the Macquarie Medical School, for example. We already have a shortfall of intern places Australia-wide. I acknowledge that there are drastic shortages of multiple specialties in many rural and remote areas, however. We need to do more on the distribution of doctors according to the health needs of all Australians. It will be interesting to see if the bonded scheme (of which I'm a part) will make any appreciable difference to healthcare service supply in areas of real demand.

My concern is that the current rate of supply, with no change in training position numbers, will mean that junior doctors have to do more to improve their resumes to get a chance for interviews – full-time work, additional university degrees/PhDs, and college requirements. To do more, there is a price to pay – a growing concern for the mental health of training doctors. Furthermore, 20 years down the track we may be looking at thousands of people with medical degrees (even specialists) unable to find secure employment.

Name an experience, event or person that has had a lasting influence on your medical career

I recall a 'Round Table Dinner' I attended whilst living on residence at St Hilda's College at the University of Melbourne. Professor Hugh Taylor AC was the speaker. He is an Ophthalmologist and the Head of the Indigenous Eye Unit at the University of Melbourne. He spoke about being involved in the College of Ophthalmologists' National Trachoma and Eye Health Program fieldwork in the 1970's – made famous by Fred Hollows. It struck a chord, as I already had an interest in Indigenous health, and actually enabled me to do research about trachoma surgical techniques in Alice Springs during medical school. It was also part of the reason for being involved in the Indigenous Health Stream that ANU Medical School offers.

How did your experience as a hospital wardsman prepare you for work as a hospital Doctor?

It was a great part-time job, and got me fantastic exposure to the logistics of a hospital. It made me appreciate that there are so many cogs in the hospital machine that are all essential – theatre preparation, cleaning, waste disposal, restocking, repair of broken items, staff management, and patient flow. I developed an appreciation of the patient journey though the hospital, and enjoyed chaperoning them through a small part of their experience (even though they wouldn't have remembered).

What would you say is the most rewarding part of being a hospital doctor?

Being ultimately responsible for each patients' care, being their advocate, having a say in how they are treated, and being involved in their journey, I would say. Bearing witness to patients recovering and/or deteriorating is such a special, privileged experience that I hope I'll never take for granted.

Also, medicine is just so fascinating, it never ceases to amaze me, though the ever-expanding horizon of knowledge is quite daunting!

What would your wife say is your most annoying habit and have you made an attempt to change your ways?

She is happy that I vacuum and clean the shower, but I get 'the stare' when biting my fingernails! Perhaps when there are no more exams to complete or courses to do, then I'll stop?

AMA response to report on GP After-Hours Services

BY CHRIS JOHNSON*

The AMA has provided its comments on the MBS Review Taskforce's preliminary report, *Urgent After-Hours Primary Care Services funded through the MBS* ('the report').

In its submission, the AMA acknowledges that access to after-hours GP services is a critical part of the health system, while recognising that poor models of after-hours GP care have the potential to fragment patient care, result in poorer outcomes for patients and incur additional costs to the health system.

In considering reform in this area, the AMA has emphasised that it is critical that services providing after-hours GP care, particularly those that operate exclusively in the after-hours period, adopt a collaborative model that complements the care provided by a patient's usual GP or through their regular general practice.

The AMA is pleased to see that the Taskforce has recognised within its report previous concerns raised by the AMA, particularly the fact that direct marketing and the promotion of after-hours home visits as being free and easy to access has driven much of the growth we have seen in the use of urgent MBS items, as opposed to genuine patient need.

Overall, the AMA submission agrees with the principles that underpin the report, and the logic behind its recommendations. However, the submission highlights concern that some of the recommendations will potentially undermine the viability of genuine medical deputising services (MDSs) and significantly impact on access to care for patients.

While agreeing that there is scope for some MBS savings through the better targeting of funding for urgent after-hours GP services, the AMA submission says the extent of the likely financial impact of the Taskforce's approach is significant and this is not recognised or well addressed in its report.

The submission recommends more work is required to explore different funding arrangements for genuine MDSs, including a revised MBS item number structure for MDS doctors or, as suggested by the 2014 Jackson Review of After-Hours Services, the adoption of a blended funding model. In offering to work further with the Taskforce and the Government, the AMA recommends that this work should be guided by the following principles:

- Services remain highly accessible to patients, but based on clinical need, not convenience;
- Arrangements complement the services provided by a patient's usual GP or through their regular general practice;
- The value of services being provided to patients is appropriately recognised;
- Services are of an appropriate quality, including the infrastructure required for triaging, supervision, training as well as communication with a patient's regular GP;
- Unpredictable and uneven service demand is recognised; and
- MDSs have access to and utilise an appropriately skilled workforce.

While the Taskforce has been limited by its terms of reference to a review of existing MBS item numbers, the AMA believes that this only represents one component of the necessary reform to after-hours arrangements. While some of the concerns expressed to the AMA by members can be addressed to an extent by potential changes to MDS funding arrangements, the AMA emphasises that a broader package of reforms is required to ensure high quality and appropriately targeted services. These will need to address issues such as:

- MDS workforce skills, training and supervision;
- MDS accreditation arrangements;
- Patient triage processes;
- Direct to consumer advertising; and

- The necessary link between an MDS and a patient's usual GP or regular general practice.

While the AMA submission expresses reservations about the extent of the impact of some of the report's recommendations, as highlighted earlier, it does agree that MBS savings can be found and justified. In this regard, the AMA response highlights the significant funding pressures on general practice, including the lasting impact of the MBS freeze, and the critical need for any savings to be re-invested to support general practice.

** Chris Johnson is the Editor of Australian Medicine magazine. This article first appeared in the August Edition (Issue 29.14) of Australian Medicine.*

Doctors' health resources

Are you looking for a GP?

If you're a junior doctor or medical student and looking for a GP please contact AMA (ACT) and we will assist you to find a local GP.

Doctors' Health Resources online

AMA's Doctor Portal:
https://www.doctorportal.com.au/doctorshealth/resources/

JMO Health:
http://www.jmohealth.org.au/
Partly funded by DHAS and a range of other organisations.

Doctors Health Advisory Service
http://dhas.org.au/resources/resources-for-junior-medical-officers.html
On the DHAS website itself.

AMSA students and young doctors:
http://mentalhealth.amsa.org.au/about-the-campaign/
http://mentalhealth.amsa.org.au/keeping-your-grass-greener/

We think of you – think of us: Doctors' Health Advisory Service

BY GARRY WALTER* & SARAH FOSTER*

What a fabulous article about doctors' health by Dr Louise Stone ('A GPs Open Letter to Young Doctors') in last monthís issue of *Canberra Doctor*, imploring young doctors to have their own GP. That message resonates with a key piece of advice invariably given by the Doctors' Health Advisory Service NSW & ACT (DHAS) to callers of our service: regardless of career stage, having oneís own GP is a plank for current and future health care needs.

Further to Dr Stone's article, it is worth reminding readers about the availability of the DHAS in the ACT. The DHAS was founded in 1982 to assist medical practitioners with personal and health problems. It is an independent and confidential service offering advice, support and, where required, referral pathways for doctors, medical students, their families and colleagues. Anecdotal research tells us that doctors often feel uncomfortable or unable to speak to their colleagues or supervisors when they are experiencing distress. The DHAS aims to provide a service where you can feel safe discussing any issues that may be impacting you either professionally or personally. The DHAS is also available should you feel concern for a colleague or family member and wish to discuss how best to manage that situation.

The DHAS is an advisory, not treatment service. How does it currently operate? The DHAS provides a 24-hour phone line, which is manned by an answering service. Calls are then returned by qualified DHAS staff (a psychiatrist and medical social worker) or affiliated health professional. Callers are not required to leave any identifying data, only a phone number to enable a return call to be made. Depending on the nature of the call and discussion with the caller, advice will be provided about "next steps", if these are needed. The next steps may take the form of one or more of the following:

- Subsequent discussion between the caller and the DHAS staff or associate.
- Referral(s) may be suggested to a GP, psychiatrist, drug and alcohol specialist, other medical specialist, psychologist, or other allied health professional.
- On a case-by-case basis, and with the caller's permission, the above-named professionals may be contacted by the DHAS to facilitate the referral.
- An offer is always made to the caller for ongoing contact and support with the DHAS.

Importantly, the DHAS is not an emergency service – the answering service advises callers to contact 000 in the case of an emergency.

The DHAS's role extends beyond providing phone advice. The DHAS provides education and training in the area of doctors' and students' health and wellbeing, and fosters relationships with key stakeholders. Indeed, in March 2017 the DHAS, in conjunction with the Medical Benevolent Association NSW, convened a fully subscribed round-table forum in Canberra, titled "Our Health and Wellbeing". Doctors, medical students and others in attendance voiced concern about various matters occupying their minds and sometimes affecting their health: increasing competition in the profession, arduous work conditions, harassment, alcohol use, mandatory reporting, dealing with stress outside work, the "psychological" hurdle in accessing care for oneself and knowing how to proceed, were issues that were raised and discussed at the forum.

In view of these stressors, unsurprisingly the number of calls to DHAS from students and doctors in NSW and ACT with myriad health concerns has almost trebled in recent months. If required, we trust that we can assist you, so do think of us – we welcome your call on 02 9437 6552 (website: www.dhas.org.au). The DHAS also plans to hold a "Caring for Colleagues" symposium in Canberra later this year, in which practical ways to respond to fellow doctors and students with health concerns will be examined.

Finally, the DHAS will be hosting the biennial Australasian Doctors' Health Conference in Sydney from 14th-16th September 2017. The conference promises to be a fantastic opportunity to focus on our health and wellbeing and the health and wellbeing of our colleagues – we warmly welcome you to join us. For further information, visit www.adhc2017.org.au.

** Professor Garry Walter AM, MB BS, BMedSc, PhD, FRANZCP, Medical Director, Doctors' Health Advisory Service (NSW & ACT)*

** Sarah Foster BAppSc, BSW, MSW (Health), Medical Social Worker, Doctors' Health Advisory Service (NSW & ACT)*

Every two minutes, a woman dies in pregnancy somewhere in the world. Send Hope ... Not Flowers

BY PROF STEVE ROBSON

Australia is one of the safest places in the world to have a baby, or to be born. There are certainly some inequalities – Aboriginal and Torres Strait Islander women face higher risks of a preterm birth, for example – but all things considered Australia is a great place to have a baby.

Yet a short plane flight from our shores it is a very different story. Papua New Guinea has one of the worst rates of maternal death in the world. About one PNG woman in 20 will lose her life while pregnant. The majority of women giving birth have no skilled birth attendant with them. The story is similar in many other Pacific nations.

Across the Pacific women face incredible disadvantages. A combination of geographical factors, economic circumstances, and societal standards all conspire to make pregnancy dangerous and disempower women. If you look around most primary school classrooms, one of the young girls you see will lose her life in pregnancy.

Many of you will be aware that the Millenium Development Goals (MGDs) passed into history with little actually achieved for women. MDG5 – reducing maternal mortality and achieving universal access to reproductive health – yielded the worst result of all. That women continue to suffer in pregnancy in 2017 should be an international scandal.

Death is an everyday occurence

During my 26 years of full-time obstetric practice, I have had only one woman die in pregnancy. Many of my colleagues, particularly younger obstetricians, will never have seen a maternal death. In Australia, direct maternal deaths occur once in about 20,000 births. It is entirely possible never to see a woman die during an entire obstetric or midwifery career. This is a testament to standards in Australia.

When I was on a teaching visit to Papua New Guinea last year, every single obstetric trainee I was teaching had personally dealt with pregnancy-related deaths in the month or two before. Rather than becoming inured to this level of suffering and loss, all of the trainees were distressed and upset. Because such outcomes are so common does not make them any more bearable.

About eight years ago, I began a journey to try to do something positive. I had been struck by the incredible amount of money spent on flowers for my private maternity patients. Each morning I would work through my ward round, and all of the new mothers' rooms would be filled with beautiful flowers. Yet on the day the woman and her new baby left the maternity ward to return home, the flowers were usually thrown out. Hundreds and hundreds of dollars were wasted.

It struck me that birth was such a time of goodwill and generosity, with family and friends wanting to express congratulations, that it might be possible to put this to humanitarian use. So was born the not-for-profit S*end Hope Not Flowers*. Through our website sendhope.org people wanting to celebrate a birth can spend the money they would have spent on flowers, instead on a maternal health project. In place of flowers, women receive a card with well wishes, and the comfort that their safe birth has been celebrated by contributing to a safe birth in the Pacific.

Taxing times

Send Hope Not Flowers is unusual as a charity. We have no paid staff, instead a group of committed and hard-working volunteers who perform their duties pro bono. Because of goodwill and generosity, the only money lost from donations is for banking charges. Even the printing and postage of the cards is paid from our own businesses.

Because almost all the money we raise is spent on aid projects overseas, it was not possible to obtain automatic tax deductibility. For Australian not-for-profit organisations to be eligible for tax-deductible status, the majority of money raised must be spent within Australia. More than 96% of donations to *Send Hope* went directly to overseas projects.

This had two effects – not being tax deductible made it very difficult to entice larger corporate donors and sponsors, and it also made some potential donors suspicious. The paradox was that if we had spent most of the money we raised on staff pay, travel, and perks, we would have qualified for tax deductibility! We were victims of our own probity.

Aiming to become gazetted for overseas deductible gift recipient status is a massive bureaucratic challenge. It took the *Send Hope* team more than three years of careful negotiation with DFAT, as well as the Treasury and other Commonwealth Departments, to crack this ultimate barrier. It was an incredible thrill for us to finally achieve tax deductibility in June this year. We were one of only four charities in the entire country to achieve this in the last two years.

We were thrilled to receive an invitation to meet Foreign Minister Julie Bishop in her office a few weeks ago, and gave us an inkling of what we had achieved. Now, all donations to lifesaving maternal health projects through *Send Hope* are fully tax-deductible.

What helps?

If a woman doesn't become pregnant, she is not going to die from a pregnancy complication or unsafe abortion. Family planning should be the first and foremost strategy to help women in the Pacific. Unfortunately, there is enormous unmet need for family planning in Pacific countries. Unwanted pregnancy is a disaster for women, their families, and their communities.

There are various reasons for this sorry situation, but the most important is that women are disempowered. They are at economic disadvantage, often geographically isolated, and at the mercy of men. It is a very sad fact that misogyny is at the heart of many of these problems. Most women in the Pacific are brought up to think themselves second class citizens. It is a regrettable and dangerous state of affairs.

Once pregnant, women have a burden of chronic disease – malaria for example – and poor nutrition and preventive care. Access to skilled pregnancy carers is scarce, and many women will have limited or no access to antenatal care as we recognise it. Skilled and trained birth attendants are few and far between in many places. Large health centres and hospitals are under-resources and stressed, placing enormous pressures on the dedicated staff running them.

Access to safe and hygienic birth practices, surgical facilities, and lifesaving medications such as antibiotics or blood transfusions, all are severely curtailed. Many women must travel for days to reach a health centre, and have little support when they arrive. Escalation and retrieval chains are poorly developed, if they exist at all.

The way forward

Women's health is not an abstract issue, and cannot be isolated from the social and political environment in which women live. Women who are disempowered are prevented from reaching their human, social, economic, and intellectual potential. Unfortunately, one of the major barriers facing women and girls in Pacific nations is culture of discrimination.

In many regions women are brought up to believe themselves second-class citizens, and commonly are subject physical, sexual and emotional violence. Violence imposes high costs – both direct and indirect – on society and the wider economy. When women's low status is low it limits their access to healthcare of an appropriate standard, and hampers their power to make decisions about their own sexual and reproductive health.

For these reasons, it is unlikely that large improvements in the health of women will happen without major societal changes. This should not be a disincentive to trying to help – it should not daunt us. The challenge should not overwhelm us. It should never stop us from trying to send hope.

Employers: beware of sham contracts

BY DOMINIQUE EGAN AND ZOE HAMILTON*

A recent article published in Australian Doctor stated that 'GP practices are employing receptionists on so-called 'sham contracts' to avoid paying annual or sick leave'.

Sham contracting in general practice remains an issue that is not limited to the hiring of administrative staff, and employers can find themselves in hot water with the Fair Work Commission if they fail to have appropriate contractual arrangements in place for any members of staff, including health practitioners.

In the Federal Circuit Court decision of *Fair Work Ombudsman v Australian Sales & Promotions Pty Ltd & Anor* handed down late last year, an employer company and its Director were fined $124,000 after it was found that it had blatantly characterised the working arrangements it had with a charity collector as an independent contractor instead of an employee. The consistent message from the Fair Work Ombudsman to employers is that there may be serious financial consequences for those seeking to evade the minimum employment conditions provided by the Fair Work Act 2009 (Cth) (the Act) by contriving to make employees independent contractors.

There have been decisions by the Federal Circuit Court in which workers have been 'complicit' in sham contracting arrangements to gain tax benefits, however adverse findings have still been made against the employer.

What is sham contracting?

A sham contracting arrangement occurs where the working relationship with a staff member is described as an independent contractor arrangement, when really it is not. The Act defines sham contracting arrangements to include:

- An arrangement whereby representations are made to an employee that they are engaged as an independent contractor when really they are an employee;
- An independent contractor arrangement which is entered by an employee due to the employer dismissing or threatening to dismiss the employee; and
- An independent contractor arrangement which is entered by an employee based on a knowingly false statement by the employer.

Independent contractors, unlike employees, are not entitled to be paid for leave, overtime or penalty rates and must make their own deductions for superannuation and taxation. Whilst independent contractor arrangements can be appealing to an employer, and particularly to small businesses, they must only be used appropriately.

Independent contractor or employee

There is no single indicator which determines whether a person is a contractor or an employee. Each determination is fact specific and Courts always look at the totality of the relationship between the parties and the arrangements behind the written contract when determining the status of a person's employment.

An employee should not assume that an individual has been validly engaged as an independent contractor simply because they hold an ABN and provide invoices for the work performed. Some of the characteristics which are considered by the Court when determining whether a person is engaged as an employee or an independent contractor are:

The degree of control over how, when and who performs the work;

Whether there is an expectation of ongoing work;

Who bears the assumption of risk in the performance of the work;

Whether the worker is entitled to allowances and penalty rates;

- Whether the worker is paid superannuation;
- Whether income tax is deducted by the employer;
- Who provides equipment and tools;
- Method of payment; and
- Leave entitlements.

How do I avoid sham contracting?

A few things to consider:

Assess the relationship: Identify the appropriate characterisation of a worker at the outset. Where there is uncertainty about the correct classification of a worker, seek legal advice regarding this and the preparation of appropriate contractual terms. Be honest and upfront with staff, both during the recruitment process and thereafter, about the nature of their engagement.

Document the arrangement: Document the relationship accurately and appropriately through written contractual terms. This is the first place the regulator or a court will look to determine the true nature of the relationship.

Donít leave it to the worker: No defence exists that a worker willingly entered into a contracting arrangement for their own benefit.

Take responsibility: Substantial penalties can be imposed for engaging in sham contracting arrangements, and liability can extend beyond an organisation. For instance, a decision-maker can be held independently liable for engaging in sham contracting. This means you could be joined with your organisation in any prosecution by the regulator.

If you require advice about your contractual arrangements with any members of your staff, please contact Dominique Egan or Zoe Hamilton.

** This article was written by Dominique Egan, Health & Aged Care Partner and Zoe Hamilton, Senior Associate at TressCox Lawyers. Dominique_Egan@tresscox.com.au P. (02) 9228 9261*

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The Medical Benevolent Association of NSW – Can we help?

Jan is a 45 year old GP with 3 teenagers. She is a single parent as a result of family violence. She was managing OK until she was diagnosed with Lymphoma. She tried to work during treatment but the side effects got the better of her. She had no income protection insurance and Centrelink payments were delayed by an overdue tax return. Janís colleagues encouraged her to call us. MBANSW helped Jan by covering one week rent per month for 4 months, her private health insurance and one electricity account. When she was able to return to work MBANSW covered her medical registration, and one quarter of her indemnity insurance. Jan has had clear scans for the past 2 years.

The Medical Benevolent Association (MBANSW) wants to help Doctors in NSW and ACT get back on their feet and back to work if possible. MBANSW is a registered Charity funded solely by your generosity. The Association is governed by a Council of 20 registered medical practitioners who have diverse professional and personal backgrounds. The day to day management is undertaken by 2 part time employees- the Executive Officer/Social Worker and the Accountant.

MBA assistance

Our priority in giving a helping hand is independence. The social work and financial support we give is planned, targeted and short term. The financial help we give is supplemented in every case by social work support and advice. We recognise that financial stress is a significant factor in general health and recovery.

In 2016, we gave $250,000 in direct assistance to medical practitioners. Our targeted support is aimed at (but not limited to):

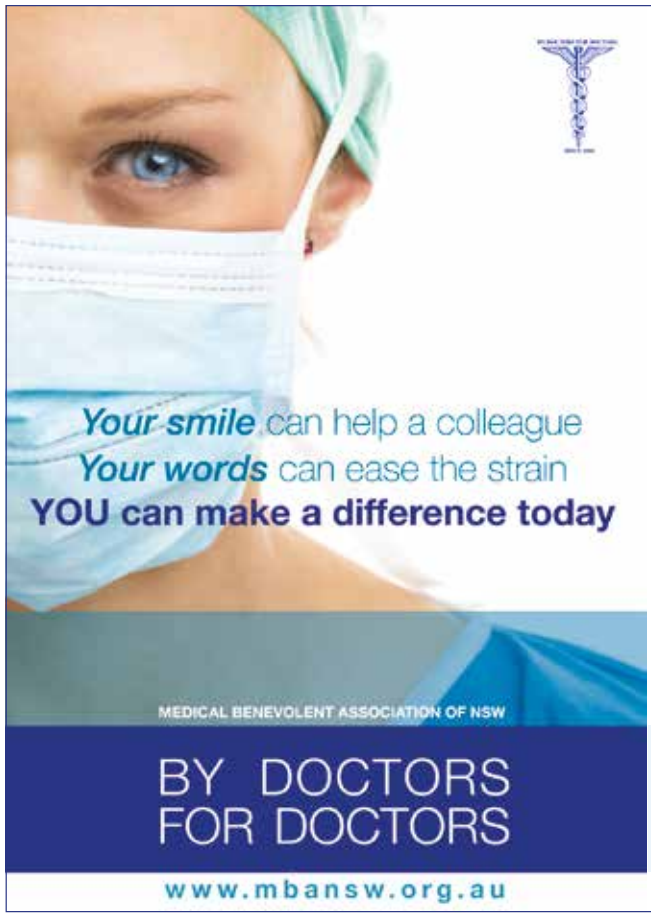
Accommodation costs and food on the table. You may be surprised to know that there are a number of doctors who are struggling to pay their rent or electricity.

Access to good health care. If a doctor is unwell, a swift recovery may be dependent on the timing and quality of the medical care they receive. We may help with private health insurance, pharmacy or other health needs.

Return to work expenses. After time off work for illness, it is quite possible that treatment costs have eroded savings. We may help with medical registration, indemnity insurance and other work expenses to get the doctor back to work as soon as possible.

If you or someone you know could do with a hand, please contact our social worker Meredith McVey through our website www.mbansw.org.au or by telephone on 02 9987 0504. Please call to talk through your situation or if you are worried about a colleague. Your call is confidential. MBANSW is an independent organisation and does not disclose any information without your permission.

Thank you to our generous donors, every dollar you donate makes a difference to your colleagues in need. If you would like to support your colleagues in need you can make a donation via our website.



The Medical Benevolent Association of NSW (MBANSW)

Provides a free and confidential support service to Canberra doctors in need and their family. Financial assistance and counselling support are available to colleagues who have fallen on hard times through illness or untimely death. Support is also available to medical practitioners who may be experiencing difficulties at work or in their personal relationships.

The MBANSW is funded by your donations; please allow us to continue to provide support and assistance to your colleagues in need by making a donation to the Medical Benevolent Association Annual Appeal. Donations can be made visiting our website www.mbansw.org.au

If you are concerned about your own situation or that of a colleague, please contact the MBANSW Social Worker,Meredith McVey on (02) 9987 0504.

Reducing waste and improving your environmental footprint: in the clinic or hospital

BY DR ANGUS FINLAY, ACT BRANCH, DOCTORS FOR THE ENVIRONMENT AUSTRALIA

Doctors have a proud history of standing against threats to human health: The medical profession played a key role in highlighting the risks to health posed by smoking and, at the height of the cold war, doctors advocated strongly against nuclear war.

The Lancet has identified climate change as both the greatest threat and greatest opportunity for public health in the 21st century.

The challenge now is to act for the planet.

A few facts

Global average temperature records are broken every year, and our atmospheric carbon dioxide concentration is higher than at any time in the past 15 million years. In fact, when CO2 levels were last this high during the Middle Miocene period, the Earth was approximately 3–5°C warmer, and average sea levels were 40–70 metres higher.

In the face of such dire potential outcomes, it is easy to become disheartened and disengaged. However, due to the very long geological time scale that our planet operates on, it is likely that we still have time to act to reduce our carbon emissions and prevent these dire consequences.

What can doctors do?

As doctors, we play an important role in reducing the environmental footprints of health services and in educating the public about the links between climate change and human health.

At an individual level:

- **Rational investigation, prescribing and intervention can significantly reduce emissions.** Every test, procedure and medication has an inherent carbon footprint. Rational practice is already being embraced by proponents of healthcare sustainability, and the additional environmental sustainability is a great bonus.
- **Reduce waste associated with procedures.** In some situations it makes sense to take only the items that you need rather than a large 'pack' that may contain extras that will not be used, and cannot be reused.
- **Think about whether a reusable option exists.** This is of particular relevance for items that can be sterilised rather than discarded. There is often a huge carbon footprint associated with procedural equipment, and if it can be safely sterilised again, choose it over the single-use only option.
- **Consider active or public transport options to get to work.** If you can get your daily exercise by riding a bicycle or walking, not only do you free up the time you may have spent at the gym, increasingly studies suggest there is a substantial boost to cognition and wellbeing! Many workplaces have good shower and bicycle lockup facilities, especially here in the ACT.
- **Consider whether you can utilise substitutes for in-person appointments, where appropriate.** Telehealth is playing an increasing role in healthcare, and we may be able to utilise these capabilities to improve convenience for our patients and reduce carbon emissions associated with their travel.
- **Turn off lights in rooms that are not in use and change lights to low-energy options**
- **Recycle where possible**

When providing lifestyle-related health advice for patients:

- **Educate patients about the impact of exposure to negative environmental health determinants, such as air pollution and heatwaves.** Aside from its role as the main driver of climate change, fossil fuel usage is also associated with poor air quality. Air pollution is considered to contribute 3000 excess deaths in Australia per year.
- **Encourage prioritising active transport where appropriate.** The wealth of literature on the physical and mental effects of exercise may be the motivator your patients need to begin an exercise program. The Australian Physical Activity Guidelines (2014) recommend at least 30 min of moderate physical activity on most days for adults. If your patients can integrate this into their days as incidental exercise to and from work or other engagements, thereby reducing transport emissions and improving urban air quality, even better!
- **Maintain a healthy, broad and balanced diet.** Red meat is a particularly carbon-intensive food source, and current evidence suggests Australians eat more than what is required for a healthy diet. In fact, the NHMRC Australian Dietary Guidelines (2013) suggest that Australian men would benefit by eating less red meat per week, recommending a weekly maximum of 455g of lean, cooked red meat. Nuts, seeds, legumes, beans, tofu, poultry, eggs and fish are all good alternative protein sources and are generally less carbon intensive.

At an organisational level:

- **We need to continue to advocate for improving healthcare sustainability.** Organisations can undertake

quality improvement cycles to reduce waste, which are often informed by waste audits performed within operating theatres, emergency departments and wards. You may be amazed by how a single letter to or conversation with managers can lead to change. The WHO has created a framework to assist with effective engagement.2

- **Individual practices can engage private environmental auditors** for expert advice in how to improve their sustainability; this can also lead to financial benefits over time for the practice.
- **We must ensure our organisations make it easy for us to take the environmentally-friendly option.** For example, co-location of recycling bins with other waste bins and providing secure cycling facilities and showers are two simple ideas.

The suggestions above represent a starting point. There are many excellent resources available on-line that provide advice on reducing your carbon footprint within your personal life. If you wish to become involved with an organisation for environmentally-minded health professionals, consider joining Doctors for the Environment Australia (www.dea.org.au). Below is a link to DEA's climate change and health policy.3 DEA meets on a second-monthly basis here in Canberra, and there are excellent opportunities for becoming involved at local and national levels.

Dr Angus Finlay is Chair of the ACT Branch of Doctors for the Environment Australia, and is a Registrar at The Canberra Hospital and Calvary Hospital.

Further reading

1. WHO: Healthy hospitals, healthy planet, healthy people: Addressing climate change in healthcare settings: http://www.who.int/globalchange/publications/healthcare_settings/en/
2. DEA Position Statement on Climate Change and Human Health: https://www.dea.org.au/revised-climate-change-and-health-policy-and-position-statement-healthy-planet-healthy-people-dea/

Sports anti-doping and therapeutic use exemptions

BY BRONWYN FAGAN*

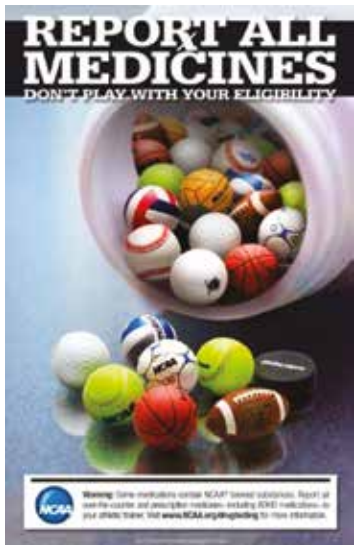
If an individual who participates in sport, regardless of the level of competition, has a genuine therapeutic need to use a prohibited substance or method as part of their treatment, then they may be eligible to apply to the Australian Sports Drug Medical Advisory Committee (ASDMAC) for a Therapeutic Use Exemption (TUE).

Even individuals who do not necessarily consider themselves to be an "athlete" need to be mindful of the medications they are taking, in case they come to the attention of their sport's national body, or the Australian Sports Anti-Doping Authority (ASADA) in connection with a possible anti-doping offence. For example if an individual plays club football, or netball, or participates in amateur level swimming or gymnastics or tennis competitions, they may be subject to random testing, or testing as a result of a whistle-blower.

Most sports will include their TUE processes in their ASADA-approved Anti-Doping Policy, but some will have a separate policy or guideline that will be available to all members.

Check the Substance – GlobalDRO

Individuals may seek medical advice about dietary supplements. It is important to remember that when it comes to anti-doping offences, an individual is responsible for whatever is found in their system, but it can assist in reducing the length of time an athlete is banned from participating in sport if they do take reasonable steps to check a substance – including by speaking with a medical practitioner, and relevantly searching a tool such as ASADA's online *'Check your substances on GlobalDRO'* at http://www.globaldro.com/AU/search .



This tool may be used by athletes or medical practitioners, and it provides useful information about brand names, active ingredients and methods of administration. GlobalDRO will also show whether the substance is banned at all times, or only 'in-competition'. Substances banned only in-competition cannot be taken during the period 12 hours prior to the scheduled start of competition until the completion of doping control, but also must not be found in an athlete's system during that period (regardless of time of administration).

A reference number for each GlobalDRO search is provided to assist in proving that steps were taken to check the status of a substance.

TUEs

There are two types of TUEs – 'retroactive', which is applied for after the prohibited substance is taken (and generally following a doping control test); or an 'in-advance' TUE, which is applied for prior to administration.

TUE applications are submitted to ASDMAC through ASADA, in strict confidence, and they must include adequate supporting documentation from the treating doctor. The TUE form gives the following guidance:

The medical evidence should include clinical history and the results of all examinations, investigations, imaging studies and specialist medical reports. Copies of the original reports or letters should be included when possible. Evidence should be as objective as possible in the clinical circumstances and in the case of non-demonstrable conditions, independent supporting

medical opinion will assist this application.

ASDMAC may seek additional tests or information in order to properly consider whether the application satisfies the criteria, which allows for use if:

- the sport's anti-doping policy allows the athlete to seek a TUE for use of a banned substance for a legitimate therapeutic purpose;
- there is no alternative substance that is not prohibited in sport, that could be prescribed to treat the athlete's medical condition; and
- there is no evidence that the athlete will gain a performance enhancement effect by using the substance.

Sports have their own specific eligibility criteria as to whether an athlete requires an in-advance, or retroactive TUE. The in-advance TUEs are generally only available to the higher level athletes.

It is important to be mindful that individuals who are involved in sport at a lower level may not need to apply for a TUE until after testing (or after it has been determined they have used a prohibited substance through non-analytical means), but they still must take reasonable steps to ensure the medication they are taking is necessary and properly prescribed, and administered in accordance with the doctor's prescription.

If an athlete is administered a prohibited substance, or uses a prohibited method (including intravenous infusions or injections of more than 50ml per 6 hour period) in an emergency situation; if insufficient time was available for a TUE application to be finalised; or if WADA and ASDMAC agree that general fairness allows it, then the athlete is able to apply for a retroactive TUE.

Retroactive or In-advance TUE?

There is a publicly accessible list of sports and criteria that shows which athletes need an in-advance TUE on the ASADA website at: https://www.asada.gov.au/therapeutic-use-exemption

Generally the relevant athletes are those in ASADA's or their sport's Registered Testing Pool, and any others competing at national level or above. Athletes on the fringe of national level need to be aware of the requirements for higher level athletes in case they are selected for higher duties for their sport and their TUE eligibility changes, meaning they must have an in-advance TUE.

If the athlete in question does not meet the criteria for an in-advance TUE, they should take reasonable steps with regard to checking the medication that contains a prohibited substance, carefully follow the doctor's instructions for taking the medication, and ensure they have adequate evidence to be able to establish eligibility for a retroactive TUE should they be tested.

Athletes can check their status with their sport. Further information about the evidence needed for retroactive and in-advance TUE applications can be found on the WADA website at: https://www.wada-ama.org/en/what-we-do/science-medical/therapeutic-use-exemptions

Drug testing

If an athlete is tested, they should ensure they declare any medication and supplements that they have taken on the Doping Control Form. This allows the analysing laboratory and ASADA to assess any results in light of what the athlete may have taken. A common example of where this is useful is if the athlete is taking the contraceptive pill, they will have higher readings of particu-

lar markers than would otherwise be expected. The inclusion of the medication on the Doping Control Form allows what would likely appear as an atypical finding (requiring further investigation) to be dealt with quickly and easily.

It is common for ASDMAC to contact (with consent) the athlete's treating doctor to discuss potential causes for an atypical finding, as well as to discuss TUE applications and any evidence a treating doctor has provided.

Further information regarding retroactive TUEs can be found on the ASADA website at:

https://www.asada.gov.au/retroactive-tue

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CANBERRA Doctor
A News Magazine for all Doctors in the Canberra Region
ISSN 13118X25
Published by the Australian Medical Association (ACT) Limited
42 Macquarie St Barton
(PO Box 560, Curtin ACT 2605)
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execofficer@ama-act.com.au
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Articles:
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